2026 Plan Year (PY)

Small Group Nongrandfathered Health Plan (Pool)

Rate Filing Checklist

## Instructions:

For each item in Section I, provide the response in this document. For each item in Section II, provide the rate filing document name as well as relevant section, page, and/or exhibit numbers.

Any Excel workbook must be submitted with a corresponding PDF that includes all information from the workbook.

* All content in the Excel file and PDF must be visible; hidden cells, hidden worksheets, and non-visible font colors are not allowed, except for functionality that was already included in official templates from the WA OIC or CMS.
* The file names must match except that the Excel workbook name should end with “duplicate.”
* For ease of reference, please add numbering to each spreadsheet tab and to a title line in the exhibits.
* **IMPORTANT: Storing amounts as values rather than linking to the source calculations results in several objections every year.**
* Retain allinternal links and formulas but break all links to external files. Ensure your rate development exhibits, for example, show how inputs and assumptions flow through the rating methodology to the final projected premium base rates; this is important for review purposes and to ensure appropriate rate development.
* *Be aware that the PDF documents are relied upon as public records. As such, prior to submitting a PDF, please review each PDF for completeness and readability*. Note: the PDF version of the actuarial memorandum exhibits can be submitted on the URRT tab rather than the Supporting Documentation tab in SERFF so that it will be uploaded to CMS. The URRT is the only Excel file that should be submitted on the URRT tab in SERFF; all other Excel files must be submitted on the Supporting Documentation tab.
* Please be aware that for plan year 2026, the OIC launched an Excel template for certain Washington State exhibits. Specific exhibits are referenced throughout this checklist. Please complete and submit the Excel file of WA Exhibits ([“Format – Rates – 2026 Individual and Small Group NonGF Health Exhibits”)](https://www.insurance.wa.gov/speed-market-tools-health-coverage-analysts) as well as the corresponding PDF file version. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file.

## Section I – General Information:

**Carrier:** **Enter Your Company’s Name**

### Market: Medical – Small Group

### Exchange Intentions: Check only one box.

Exchange Only  Outside Market Only  Exchange and Outside Market

Note: The Exchange Intentions field on the General Information tab in SERFF should match the wording for the item selected above (see the Additional Information section for the Sub-TOI by searching by TOI under Filing Rules/Submission Requirements in SERFF).

### We will offer the following: Check all boxes that apply.

At least one silver plan and one gold plan throughout each service area outside the Exchange whenever we offer a bronze plan outside the Exchange. See RCW 48.43.700.

One or more plans with a unique benefit design. See Section II #9 below.

Pediatric dental embedded.

Non-essential health benefits (Non-EHBs). See Section II #13 below.

New plans have been added, and we confirm that no previously retired Plan IDs have been reused in this rate filing. We are aware that the reuse of retired Plan IDs can cause risk adjustment reconciliation complications.

**All Plans Offered**

| **HIOS Plan ID** | **Plan Name** | **Unique Benefit Design (UBD)** | | **Pediatric Dental Embedded (Yes/No)** | **Description of Non-Essential Health Benefits (Non-EHBs)** |
| --- | --- | --- | --- | --- | --- |
| **(Yes/No)** | **If yes, briefly explain why. If no, “N/A.”** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

### Do you have any expanded bronze plans as described under 45 CFR §156.140(c) in which the variation in AV Metal Value is between +2% and +5% (i.e., the AV is between 62% and 65%)?

No

Yes, and they are listed in the table below. We confirm each of the following:

1. That the plans’ member cost-shares are equivalent to less than 50% coinsurance and
2. That each plan is either

(1) A High Deductible Health Plan 1 or

(2) Has at least one major service 2, other than preventive services, covered prior to the deductible.

Note: Only one major service needs to be listed in the table even if multiple major services are covered prior to the deductible.

| **HIOS Plan ID** | **Plan Name** | **High Deductible Health Plan (Yes/No) 1** | **Major Service covered prior to the deductible 2** | |
| --- | --- | --- | --- | --- |
| **Yes/No** | **Service** |
|  |  |  |  |  |
|  |  |  |  |  |

1 The plan meets the requirements to be a high deductible health plan within the meaning of 26 U.S.C.233(c)(2) as established at 45 CFR §156.140(c).

2 The following are considered major services. The major service covered before the deductible must apply a reasonable cost-sharing rate to the service to ensure that the service is affordably covered (HHS Notice of Benefit and Payment Parameters (NBPP) for 2018).

1. At least three primary care visits.
2. Specialist office visits.
3. Inpatient hospital services.
4. Emergency room services.
5. Generic drugs.
6. Preferred brand drugs.
7. Specialty drugs.

### Is your service area changing from Plan Year 2025?

No

Yes. We are making the following changes:

|  |  |  |
| --- | --- | --- |
| **Geographic Rating Area** | **Additional Counties Covered** | **Terminated Counties**  (a.k.a. Exited or No Longer Covered) |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |
| 6 |  |  |
| 7 |  |  |
| 8 |  |  |
| 9 |  |  |

### Network Information:

|  |  |  |  |
| --- | --- | --- | --- |
| **Network Name** | **Type**  (EPO, HMO, POS, or PPO) | **Tiered or Single** | **Date Filed** |
|  |  |  |  |
|  |  |  |  |

### Rate filing file names for Parts I, II, and III of HHS Forms: (Requirements per RCW 48.02.120(5) and 45 CFR §154.215.)

Name the Parts I, II, and III according to the instructions provided in Washington State SERFF Life, Health and Disability Rate Filing General Instructions.

## Section **II – Experience Data and Projections**

For each item, provide the rate filing document name and section number, page number, and/or exhibit number that addresses the item.

For example: (1) “Part III Rate Filing Documentation and Actuarial Memorandum,” Section III or (2) “Supporting Documentation File,” Exhibit 5.

For items that require justification, please indicate where to find both narrative and technical details.

| **Line** | | **Task** | **Issuer Response:** | |
| --- | --- | --- | --- | --- |
| **Document Name** | **Section / Page / Exhibit Number** |
| **EXPERIENCE PERIOD DATA** | | | | |
| **1** |  | **Complete Experience:**  Include the complete experience for all 2024 small group plans.   * Net of Rx rebates: Any prescription drug claims should be net of rebates received from drug manufacturers; please document in the Part III Actuarial Memorandum where and how this is addressed. * Note: if financial data paid through March 2025 is not directly used as the foundation for this rate filing, discuss why the March 2025 data was not available. Discuss what data was used instead and how it was or was not adjusted to mimic data paid through March 2025. |  | |
| **a** | Financial data consistency:  Demonstrate that the financial data, including the member months, in (i) URRT Worksheet 1, Section I General Product and Plan Information, (ii) URRT Worksheet 2, Section II Experience Period and Current Plan Level Information, (iii) the WAC 284-43-6660 summary, and (iv) the actuarial memorandum exhibits are consistent as of March 2025. If not consistent, explain why the discrepancy is appropriate. |  |  |
| **b** | Support for URRT Worksheet 1, Section I experience period data for 2024:  Provide separately for medical and prescription drugs (Rx), as appropriate:   * By incurred month and paid month, for claims paid through March 2025: allowed claims and incurred claims (Note that any embedded pediatric dental claims experience should also be included and will be considered part of EHB experience; see URR Instructions’ section 1.4 for additional information.) * Any annual estimated payable and/or receivable amounts (e.g., reserves, reinsurance, overpayments, rebates, and other) as of March 2025, including justification of such amounts * Any annual risk adjustment transfer amounts, including justification of such amounts * Monthly premium amounts * Monthly membership |  |  |
| **c** | Consistent with #1.b above, provide the following to support benefit category experience data in URRT Worksheet 1, Section II, and the WAC 284-43-6660 summary:   1. Provide the following separately for 2024 allowed claims and incurred claims as well as by incurred month and benefit category (i.e., categories as defined for URRT Worksheet 1, Section II, plus separate categories for each non-EHB):    * Change in reserves between the beginning (i.e., previous year’s 3/31) claim reserves and ending (i.e., current year’s 3/31) claim reserves.    * Total claims.    * PMPM (i.e., use monthly membership from #1.b above to calculate claims per member per month (PMPM)).    * Paid-to-allowed ratios of paid (incurred) claims to allowed claims. 2. Explain if EHB allowed claims were obtained from claims records or imputed from paid claims. If amounts were imputed, please elaborate about how they were imputed. 3. Demonstrate how URRT Worksheet 1, Section II, categories map to WAC 284-43-6660 summary categories. Reconcile data between the two summaries. 4. Additionally, provide related monthly information in WA Exhibit 1. |  |  |
| **d** | 2024 actual and projected:  Provide analysis of actual experience versus amounts projected in the plan year 2024 rate filing [45 CFR §154.301(a)(3)(ii)] in WA Exhibit 2.  Identify material differences in actual and expected experience, the primary source(s) of deviations, and any action taken in your 2026 projections to address deviations. Additionally, address how the business is or is not impacted by federal income tax. |  |  |
| **e** | Split up experience if you are terminating any counties in 2025 and/or 2026:  If you are terminating any counties for plan year 2025 and/or 2026, include a table splitting URRT Worksheet 1, Section I experience between continuing and terminated counties.  If you are not terminating any counties, respond “N/A.” |  |  |
| **2** | | **Manual EHB Allowed Claims:**  If credibility is 100%, respond “N/A” for each item.   * If you use a credibility-blended estimate, explain the processes in detail (i) per guidance in URR Instructions 4.4.3.3, to establish the Manual EHB Allowed Claims PMPM for WA and (ii) per 4.4.3.4 to establish the credibility percentage for URRT Worksheet 1, Section II. * Note: if the 2024 experience is 0.00% credible, then the trend, morbidity, demographic, plan design, and other factors in URRT Worksheet 1, Section II can be listed as 1.000. In that case, only analyses of the manual trend and adjustment factors are required. |  | |
|  | **a** | Manual data relevance:  Explain the relevance of the data used to determine the Manual EHB Allowed Claims PMPM. |  |  |
| **b** | Manual EHB allowed claims PMPM:   * Show the detailed calculation of the Manual EHB Allowed Claims PMPM entered in URRT Worksheet 1, Section II. * Justify any adjustments made to the data, such as adjustments for trend, morbidity, demographics, plan design, and geographic areas. Your response should clearly identify how your estimate considers the cost and utilization characteristics of your small group health plan market service area in the State of Washington. * Note: the manual rate must be developed in a manner consistent with 100% credibility. See #2.c below. |  |  |
| **c** | Credibility of experience data:  Describe the credibility methodology and assumptions used per Actuarial Standard of Practice (ASOP) No. 25.   * Identify the actuarially sound and appropriate credibility procedure used to develop your credibility estimate. * At what level is experience determined to be more than 0% credible? * How is partial credibility determined? * At what level is experience determined to be 100% credible? |  |  |
| **d** | Show how you estimated credibility of the 2024 allowed claims and member months used in rate development. Use your credibility procedure. |  |  |
| **3** | | **Experience in WAC 284-43-6660 Summary and**  **Summary of Pooled Experience with Adjustments:** |  | |
|  | **a** | WAC 284-43-6660 summary, experience:  Complete the WAC 284-43-6660 summary for Individual and Small Group Contract filings.   * Provide data to support WAC 284-43-6660 without adjustments for Risk Adjustment and High-Cost Risk Pool (HCRP) receipts and assessments. * Data should be based on the incurred years 2024, 2023, and 2022. |  |  |
| **b** | Summary of Pooled Experience with Adjustments:   * Create a document or exhibit called “Summary of Pooled Experience with Adjustments” for calendar years 2024, 2023, and 2022.   Start with the “Summary of Pooled Experience” table from the WAC 284-43-6660 summary and add the following rows:   * Risk Adjustment transfer amounts * HCRP receipts * HCRP assessments * HHS-RADV adjustments:   Indicate the source of each RADV amount and specify each applicable Benefit Year (BY) and HHS report date. List amounts from different reports on separate lines.   * Commercial reinsurance reimbursements received and expected * Adjusted Gain/Loss, excluding anticipated Medical Loss Ratio (MLR) rebates, as a dollar amount * Adjusted Gain/Loss, excluding anticipated MLR rebates, as a percent of premium * Anticipated MLR rebates * Subsequent adjustments:   If necessary, also list any subsequent adjustments for prior years according to when payments were received. Document the amount and incurred year for each adjustment. For example, if a Risk Adjustment transfer amount was received or paid in 2024 for a period prior to 2024 at an amount other than the Risk Adjustment transfer amounts above (i.e., at the top of this list), list the difference as a below-the-line adjustment to 2024 experience.   * Add a copy of this table to the Part II Written Description. * Document and justify every estimated amount. * For each federal Risk Adjustment transfer amount, identify either (1) the final federal Risk Adjustment Payments Report used or (2) the interim risk adjustment report used. Note: only use an interim report for periods when a final report is not yet available. * Note: Since the federal Reinsurance and Risk Corridor programs ended in 2016, they should not be included in the summary. |  |  |
| **c** | Changes to prior period experience:  If applicable, justify and show line-item differences in 2023 and 2022 experience in this rate filing’s summary versus the final version of the “Summary of Pooled Experience with Adjustments” in last year’s filing. Also, describe any such changes in the WAC 284-43-6660 summary under General Information #5. |  |  |
| **4** | | **Plan Level Experience and Current Data:**  Document and justify URRT Worksheet 2, Section II: Experience Period and Current Plan Level Information.   * Explain whether amounts are based on each plan’s experience or allocated to plans. If amounts are allocated, demonstrate and justify the allocation method. * Explain any differences between totals in URRT Worksheet 2, Section II and URRT Worksheet 1, Section I. |  |  |
| **TREND FACTORS** | | | | |
| **5** | | **Allowed Claims Trends:**  Trend assumptions should reflect your best estimates by URRT Worksheet 1 benefit category and one or more categories of non-EHBs, as applicable.  Rely on market-specific information for Washington State to the extent possible. Justify use of any alternative data.  As indicated in URR Instructions, describe the trend development in the Part III actuarial memorandum. |  | |
|  | **a** | Allowed claims EHB trend analysis:   * In WA Exhibit 3, provide annual EHB trends by benefit category. See instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file. * In WA Exhibit 4, provide your retrospective analysis of normalized EHB allowed claim trends. See instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file. * In WA Exhibit 5, provide aggregate actual experience (A) EHB trends, projected (i.e., expected; E) EHB trends, and actual-to-expected (a.k.a. A:E) EHB trend analysis. See instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file. |  |  |
| **b** | Allowed claims non-EHB trend analysis:  If applicable, include an exhibit that develops the non-EHB allowed claims trend. |  |  |
| **c** | Projected allowed claims trend development (EHB & non-EHB):   * As outlined in URR Instructions 4.4.3.1, describe how you arrived at your allowed claims trend assumptions, including the data used, credibility of the data used, and any adjustments made to the data. * Provide an overall allowed claims trend estimate as well as EHB breakdowns into URRT worksheet 1 benefit categories (or at least medical and prescription drug categories).   + Further break the EHB trends down into utilization, unit cost, and service mix/intensity components.   + Upload relevant EHB details to WA Exhibit 3; see instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file. * If your overall trend, indicated in URRT Worksheet 1, Section II, differs materially from the retrospective trend indicated in WA Exhibit 4, provide detailed actuarial support for the difference. Address the following:   + Actuarial support must provide both qualitative and quantitative bases for the difference. Refer to other WA Exhibits and/or separate issuer-developed actuarial exhibits for support, where appropriate.   + Prospective trend adjustments should identify all data, assumptions, methods, and models. Note that prospective trend adjustments are NOT exempt from actuarial support requirements. Reliance statements do not exempt carriers from actuarial support requirements. * Address how your estimates reflect trends specific to the State of Washington. Note that nationwide trend analysis is not sufficient support for Washington State unit cost trend projections.   + Address whether and how unit cost projections reflect projected network and provider contract changes for the projection period. Comment about how much of the provider contracting is already complete for plan year 2026 and how much of the projected reimbursement trend is already locked in for plan year 2026. |  |  |
| **d** | Independence of various utilization changes:   * Explain how you separated expected utilization changes due to (i) changes in average health status of the population (a.k.a. morbidity) versus (ii) other projected utilization changes (e.g., change in mix of services). * Clarify how the various utilization and morbidity adjustments in the rate filing are independent (i.e., do not overlap nor depend on one another). |  |  |
| **6** | | **Incurred Claims Trends:**   * Trend assumptions should reflect your best estimates by URRT Worksheet 1 benefit category and one or more separate non-EHB categories, as applicable. They should also be available for each type of service in the WAC 284-43-6660 trend factor summary. * Incurred claims trends differ from allowed claims trends in that they reflect leveraging of fixed cost-shares. * Rely on market-specific information for Washington State to the extent possible. Justify use of any alternative data. * Describe the trend development in the Part III actuarial memorandum. |  | |
|  | **a** | Incurred claims projected trend (EHB & non-EHB):  (see also #31.c of this checklist)   * Include an exhibit that develops the incurred claims trend percentages entered in the WAC 284-43-6660 summary. Justify the projected incurred claims trend percentages. * Show how to calculate the Portion of Claim Dollars for trends in the WAC 284-43-6660 summary. Note: the percentages should be based on the 2024 incurred claims dollars by trend category. The total incurred claims used in the calculation should be consistent with the incurred claims PMPM in URRT Worksheet 2, Section II Experience Period and Current Plan Level Information, Field 2.17. * Demonstrate that the overall incurred claims annual trend (EHB and non-EHB) matches (1) the annualized trend from URRT Worksheet 1, Section I General Product and Plan Information to URRT Worksheet 2, Section IV Projected Plan Level Information, Field 4.15 as well as (2) the incurred claims trend listed in Rate Review Details (see also #23.b of this checklist). |  |  |
| **URRT WORKSHEET 1, SECTION II EXPERIENCE PERIOD and CURRENT PLAN LEVEL INFORMATION, NON-TREND EHB ADJUSTMENT FACTORS** | | | | |
| **7** | | **URRT Worksheet 1, Section II Non-Trend EHB Factors:**  Explain and show the detailed calculations for actuarial assumptions underlying each non-trend EHB factor used in URRT Worksheet 1, Section II Experience Period and Current Plan Level Information. Provide actual experience, projections, and actual-to-expected information in WA Exhibit 5; see instructions in the exhibit template.   * Morbidity Adjustment * Demographic Shift * Plan Design Changes * Other   If applicable, provide a detailed breakdown of any adjustments made under the “Other” category such as significant provider network or pharmacy rebate changes from the experience period. |  |  |
| **URRT WORKSHEET 2, SECTION I GENERAL PRODUCT and PLAN INFORMATION, AV METAL VALUES** | | | | |
| **8** | | **AVC Screenshots:**  (see also #9 below)   * Provide the Actuarial Value Calculator (AVC) screenshots in PDF format showing “Calculation Successful.” State the corresponding HIOS Plan ID on each AVC Screenshot. For the 2026 AV Calculator and Methodology, see link:   <https://www.cms.gov/cciio/resources/regulations-and-guidance/index.html>   * MHSUD cost-share: You may list the MHSUD office visit cost-share in the AVC if you include justification in the actuarial memorandum that blending the cost-share with the MHSUD other outpatient cost-share has a negligible impact on the final AV Metal Value. * Please reformat the “Coinsurance, if different” cells to display the same 4-decimal place accuracy as the default coinsurance for tiers 1 & 2. Also, reformat the tiered utilization percentages to more accurately indicate the weights used in the calculation. * Metal Levels   Platinum – 90%, range -2/+2%  Gold – 80%, range -2/+2%  Silver – 70%, range -2/+2%  Bronze – 60%, range -2/+2% or Expanded Bronze +2/+5% |  |  |
| **9** | | **Unique Benefit Design for AVC (Actuarial Value Calculator):**  Note: Address this item in conjunction with #8 above.   * The actuary would be prudent to attempt to use data and assumptions that are consistent with the calculators as much as possible when adjusting for unique plan designs ([https://www.actuary.org/sites/default/files/files/MVPN\_042314.pdf](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.actuary.org%2Fsites%2Fdefault%2Ffiles%2Ffiles%2FMVPN_042314.pdf&data=05%7C01%7CJeff.Oberle%40oic.wa.gov%7Cbdd4d50ce37a44e8329c08dbc10bbae4%7C11d0e217264e400a8ba057dcc127d72d%7C0%7C0%7C638316028341686216%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=LXfhHBUbvHkjLm86NMI09sKg1mhqb%2Ftz7DLRyVLw%2FKk%3D&reserved=0)). The continuance tables in the AVC should be used, if possible, so that the adjustments are consistent with the AVC calculations. * Do any plans have a unique benefit design? If yes, for each such plan, you must: * Use one of the two methods, 45 CFR §156.135(b)(2) **or** 45 CFR §156.135(b)(3), to certify the Metal Value and provide the exact AV Metal Value for the plan. * You must also provide detailed support for your unique plan design AVs. * Please provide supporting unique AV calculations in your rate filing memorandum and exhibits. * Include enough detail for the reviewer to determine whether the methods, assumptions, and results are appropriate and reasonable. * You must provide justification for AVs when actual plan designs deviate from the AVC’s functionality, even if your actuary assumes the impact is immaterial. * **Notes About Plan Designs in the AVC:** * To be consistent with the requirements in the AVC User Guide (see FAQ Q2 & Q3), all plans with a $0 Rx or a $0 medical deductible should indicate an integrated medical and drug deductible when possible. For illustrative purposes, consider a plan with a non-zero medical deductible and a $0 drug deductible, which is equivalent to saying that none of the drug tiers (i.e., benefits) is subject to any kind of deductible: * Case 1: One or more of the drug tiers are subject to coinsurance (which, from our earlier assumption, apply before any deductible). * Case 2: Each drug tier is either fully covered or subject to a copay. * For Case 1, using a combined deductible would force the drug coinsurance(s) to apply after the medical deductible (given the limitations of the AVC with regards to entering coinsurance before the deductible). For Case 2, an integrated deductible should be used. * The reverse situation with $0 medical and non-zero Rx deductibles is similar, however, only coinsurance for the medical benefits listed in the AVC are considered. If, for example, a coinsurance is only applied to the ambulance benefit, which is not part of the AVC, a combined deductible should be applied. * *Plans that include Coinsurance During the Deductible Phase or can otherwise be described as having “Services not Subject to Deductible and without a copay”:*   Excel row 72 on the User Guide sheet of the AVC states, “Services not subject to deductible and without a copay are treated as covered at 100 percent by the plan until the deductible is met through enrollee payments for other services.” When this occurs, the AVC output is higher than that of the actual plan design; the difference depends on the size of the deductible and impact of the corresponding benefit on the actuarial value. The exact difference, however, is unknown without using an effective copay, which requires a unique benefit design, to approximate the coinsurance in the deductible range. If your plans include this type of cost-sharing design, you are required to show that their AVs are within the acceptable metal level range using unique benefit designs. See the AVC User Guide sheet FAQ Q16 for additional information.   * *Plans that include “Services not Subject to Deductible and with a copay”:*   Copays paid during the deductible range do not accumulate toward the deductible, regardless of whether the benefit is subject to deductible.   * *Plans that partition benefit categories into subcategories with different cost-share designs:*   If the plan has different cost-sharing for subcategories of benefits included in the AVC but the AVC only accepts one cost-sharing structure, you must (1) enter the cost-share variations in the Benefit Components document and (2) account for the differences between the plan design and the AVC functionality in your AV Metal Value calculations.  For example, the AVC only accepts one MHSUD (mental health/substance use disorder) outpatient cost-share structure, so if a plan design includes different cost-shares for MHSUD outpatient professional (office) visits versus MHSUD outpatient other-than-professional-visits, the plan design does not align with standard use of the AVC. |  | |
|  | **a** | If using the unique benefit design certification method in 45 CFR §156.135(b)(2):   * Provide the required actuarial certification language as well as justification and detailed calculations of how you estimated a fit of the plan design into the parameters of the AVC. * Submit one AVC screenshot for each plan to show that the benefit design after the fit is a legal metal plan. |  |  |
| **b** | If using the unique benefit design certification method in 45 CFR §156.135(b)(3):   * Provide the required actuarial certification language as well as justification and detailed calculations of (i) how the AVC was used to determine the AV Metal Value for the plan provisions that fit within the calculator parameters while (ii) appropriate adjustments were made to the AVC output(s) for plan design features that deviate substantially from AVC parameters. * Submit two or more AVC screenshots including at least one extreme high AV Metal Value and one extreme low AV Metal Value based on features like those of the plan. * Using the filed AVC screenshot results, explain how adjustments are made to generate each plan’s EXACT final AV Metal Value used in the URRT. |  |  |
| **c** | Unique Plan Design Supporting Documentation and Justification:  Include a completed Unique Plan Design Supporting Documentation and Justification form (a blank form can be found on the CMS website). Note: You may submit your own version of the official form, to accommodate your complete responses and improve readability. |  |  |
| **d** | Pharmacy tiers:  If your prescription drug tiers do not exactly match those in the AVC and you do not identify the plans as having unique benefits, please add a discussion to the Part III actuarial memorandum. Consider guidance in relevant documents such as the PY2025 QHP Issuer Application Instructions (e.g., 5.8 Suggested Coordination of Drug Data between Templates) and AVC supporting documentation. |  |  |
| **10** | | **AV Metal Values:**  (URRT Worksheet 2, Section I General Product and Plan Information, Field 1.6)  Load the final PY2026 AV Metal Values into URRT Worksheet 2 and WA Exhibit 6. Additionally, load prior AV Metal Values into WA Exhibit 6; see instructions in the exhibit template. |  |  |
| **URRT WORKSHEET 2, SECTION III PLAN ADJUSTMENT FACTORS** | | | | |
| **11** | | **AV and Cost Sharing Design of Plan Factors:**  (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.3)  Document and justify the factors including #11.a through #11.b below.  Then, address items #11.c through #11.f below. Include aggregate actual experience, projections, and actual-to-expected analysis in WA Exhibit 7; see the instructions in the exhibit template.  URR Instructions Section 2.2.3 and URRT Worksheet 2, Section III include four adjustments directly related to plan-level incurred claims rate development.   * These adjustments are the “AV and Cost Sharing Design of Plan”, “Provider Network Adjustment” (see checklist #12), and “Benefits in Addition to EHB” (see checklist #13). (The “Catastrophic Adjustment” is N/A for small group; see checklist #14.) * Do not include morbidity of the population expected to enroll in the plan (i.e., differences due to health status) per URR Instructions Section 4.4.4. * Each of these adjustments should be normalized to not double count the impact of the other factors.   **To derive the “AV and Cost Sharing Design of Plan”:**   * There are two subcomponents of the adjustment defined in WAC 284-43-6810(1); they are:   + AV pricing value, and   + Induced demand factor (IDF). * Definitions of these terms and related terms can be found in WAC 284-43-6800. * Detailed guidance related to each subcomponent of the “AV and Cost Sharing Design of Plan” is provided in this checklist in sections 11 (a)-(f). * The formula combining the subcomponents of the “AV and Cost Sharing Design of Plan” is expected to be the following: (AV and Cost Sharing Design of Plan) = (AV Pricing Value) x (Induced Demand Factor, IDF); where the AV Pricing Value and IDF are on an appropriate relativity basis.   Note the following:   * Benefit differences related to EHB-only cost sharing. See #11.a below. * Expected utilization differences due to differences in cost-sharing (i.e., induced demand). See #11.b below. * To determine aggregate weighted averages for items covered by this #11, unless otherwise specified, apply each plan’s projected membership as weights. |  | |
|  | **a** | AV Pricing Value (a.k.a. EHB paid-to-allowed factors) by plan:   * Provide the factor for each plan that shows the impact of benefit differences for EHB-only cost sharing. * See WAC 284-43-6800(3) for the definition of AV pricing value and WAC 284-43-6800(1) for the definition of AV metal value. * Per WAC 284-43-6810(3):   + Rate development exhibits should demonstrate compliance with the following:     - “The AV pricing value must be within ±2% of a plan's designated AV metal value.“     - “The allowable range of AV pricing value may be increased or decreased by 1% and must not result in a total adjustment exceeding ±3%, if the plan has significant features that are not considered in the AV metal value calculation. Applicable plan features may include, but are not limited to, an embedded pediatric dental benefit, aggregate family deductible, or significant out-of-network utilization.”     - If you are requesting the expanded AV Pricing Value range of ±3%, identify this in WA Exhibit 9 and provide supporting documentation for the request. Documentation for this request must show significant plan features impact EHBs, those plan features are excluded from consideration in the federal AV calculator and AV metal value, and those plan features have a material pricing impact supported by actuarial analysis.     - Note that AV pricing value must be actuarially sound, and the ranges referenced above should not be used as an adjustment (i.e., ceiling or floor) to AV pricing values.     - AV pricing values should be normalized for impacts of all other allowable plan-level rating adjustments (including subcomponents of the “AV and Cost Sharing Design of Plan”) and for use in the calculations of the “AV and Cost Sharing Design of Plan” factors.   + The Part III actuarial memorandum in the rate filing must include the following information related to AV metal value and AV pricing value:     - Each plan's AV metal value, AV pricing value, and the method used to develop AV pricing values.     - The methodology that was used to develop the AV pricing value including that it is based on a standardized population. The carrier must identify all material changes in the AV pricing value development and their impacts.     - Note that if you have a commercial or other (e.g., internal) reinsurance/pooling agreement, consider projected recoverable amounts in the overall AV Pricing Value. |  |  |
| **b** | **Induced demand factors (IDFs) by plan:**   * Each plan’s IDF can vary by plan design but must be consistent with the federal risk adjustment transfer formula per WAC 284-43-6810(2). Therefore, plan IDFs should be determined by the formula (AV pricing value)2 – (AV pricing value) + 1.24. * Note the following:   + The MAIR reflects average induced demand for the pool.   + IDFs adjust average pool-level projected allowed claims to plan-level amounts. IDFs reflect the impact of plan design on plan-level utilization (i.e., induced demand or anti-selection) relative to the average induced demand in the pool. IDFs should not change the overall expected allowed claims nor the paid-to-allowed claims ratio.   + Calculate the aggregate impact of your pool’s projected induced demand factors. If it is not 1.000, apply an adjustment in URRT worksheet 1’s “Other” adjustment. Such an adjustment should equal (1 / (aggregate impact of your pool’s projected induced demand factors)). The net impact should be 1.000. |  |  |
| **c** | **AV and Cost Sharing Design of Plan factors:**  (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.3)  Discuss and demonstrate the calculation of the final plan adjustment factors used in URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.3, AV and Cost Sharing Design of Plan.  See the introduction to this checklist #11 for the AV and Cost Sharing Design of Plan formula using the four subcomponents addressed in WAC 284-43-6810(1). |  |  |
| **d** | **Compare the AV Metal Value and the** **AV Pricing Value:**  Provide the comparison of the AV Metal Values and AV Pricing Values in WA Exhibits 6 and 9. |  |  |
| **e** | **Base premium rates versus CPAIR:**  Calculate the difference between the 1.0000 premium rates (i.e., age factor 1.0000 such as for age 21; area factor 1.0000; tobacco factor 1.0000 (wellness discount) for each plan in the Rate Schedule and the Calibrated Plan Adjusted Index Rate (CPAIR) amounts in URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.14. The differences should be within a few cents at most. (see also #35 of this checklist) |  |  |
| **f** | **Experience period incurred claims, allowed claims, and paid-to-allowed ratios:**  Include a table that shows by metal level the 2024 paid (incurred) claims and allowed claims experience and calculates the paid-to-allowed ratios. See also #1.c and #1.d of this checklist. |  |  |
| **12** | | **Provider Network Adjustment Factors:**  (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.4)  Demonstrate the build-up of the provider network factors. If you only have one network, please respond “N/A,” and use a factor of 1.0000.  The network factors should be normalized so that there is no change to the overall weighted average of the claim costs after the Provider Network Adjustment factors are applied. Include an exhibit demonstrating the normalization (i.e., normalize the network factors such that the following amounts match):   * Average incurred claims with risk adjustment:   Sum product of the projected membership x MAIR x (AV and Cost Sharing Design of Plan) x (Benefits in Addition to EHB) divided by the total projected membership.   * Average incurred claims with risk adjustment and provider network adjustment factors:   Sum product as described above with Provider Network Adjustment factors also incorporated. |  |  |
| **13** | | **Benefits in Addition to EHB Factors:**  (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.5)  Document and justify these factors. Note that they should be developed as loads on EHB incurred claims. See URR Instructions and 45 CFR §156.115(d) for additional information. Include aggregate actual experience, projections, and actual-to-expected analysis in WA Exhibit 7; see the instructions in the exhibit template.  If plans do not include non-EHBs (non-essential health benefits) and all plans are outside the Exchange, please respond “N/A.” |  |  |
| **14** | | **Catastrophic Adjustment Factors:**  (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.9)  For the small group market, these Plan Adjustment Factors will all be 1. | **N/A** | **Not offered in the small group market.** |
| **URRT WORKSHEET 2, SECTION III PLAN ADJUSTMENT FACTORS, CALIBRATION FACTORS** | | | | |
| **15** | | **Age Factors and Age Calibration Factors:** |  | |
|  | **a** | Age calibration factor development:  Provide the 2026 age factors and the calculation of the age calibration factor used in URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.11.  Note: each calibration factor (age, geographic, and tobacco) must be calculated independently. |  |  |
| **b** | Age calibration factors, projected versus prior:  Compare the 2026 age calibration factor to the 2023, 2024, and 2025 factors. |  |  |
| **c** | Average age:  Show the average age and provide actuarial justification for the methodology employed to calculate the average age. |  |  |
| **16** | | **Area Factors and Geographic Calibration Factors:**  See WAC 284-43-6701 for geographic rating areas effective on or after January 1, 2019.  Note, if Area 1 (King County) is in your service area, its factor must be set at 1.0000. If Area 1 (King County) is **not** in your service area, the geographic rating area of the county with the largest enrollment in your service area must be set at 1.0000. If you are an insurer new to the Washington state market, the geographic area with the greatest number of counties must be set at 1.0000. |  | |
|  | **a** | Area factor development:  Note: if your service area is limited to a single area, please respond “N/A,” since the area factor is 1.0000.  Demonstrate the build-up of the geographic rating area factors.  Document and justify the 2026 factors with details including, but not limited to, the following:   * Certify that the following items were not used to establish any geographic rating area factor: * Health status of enrollees or the population in an area. * Medical condition of enrollees or the population in an area, including physical, mental, and behavioral health illnesses. * Claims experience. * Health services utilization in the area. * Medical history of enrollees or the population in an area. * Genetic information of enrollees or the population in an area. * Disability status of enrollees or the population in an area. * Other evidence of insurability applicable in the area. * Clarify how projected unit cost changes were considered for each area. Also, clarify how credibility was considered. Like trends, you should not solely rely on historical information, especially if it is not considered to be 100% credible or if significant changes are projected in the future. |  |  |
| **b** | Area factors, highest versus lowest:  Demonstrate that your geographic rating area factors comply with WAC 284-43-6681 highest to lowest cost ratio requirements of 1.15.  Note: the higher ratios of 1.22 and 1.40 are limited to companies offering Exchange QHPs, which is not currently available to the Washington small group market. |  |  |
| **c** | Area factors, projected versus prior:  Compare the 2026 area factors and calibration factor to the 2023, 2024, and 2025 factors. If the 2026 factors did not change from those in the prior filing, indicate why the factors did not change; indicate when the factors were last evaluated and what data was used in that evaluation.  Note: Our opinion is that the geographic area factors should be regularly evaluated. |  |  |
| **d** | URRT geographic calibration factor:  Provide the calculation of the geographic calibration factor used in URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.12.  Note: each calibration factor (age, geographic, and tobacco/wellness) must be calculated independently. |  |  |
| **e** | Load area factors into URRT:  Provide the geographic rating areas and rating factors in URRT Worksheet 3. |  |  |
| **17** | | **Tobacco/Wellness Factor and Tobacco/Wellness Calibration Factor:** |  | |
|  | **a** | Tobacco use (wellness) factor development:  Document and justify the 2026 Tobacco Use (Wellness) factor. If the factor did not change from the prior filing, indicate when the factor was last evaluated and what data was used in that evaluation. Note: Our opinion is that the factor should be re-evaluated periodically. |  |  |
| **b** | URRT tobacco (wellness) calibration factor:  Provide the calculation of the tobacco (wellness) calibration factor used in URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.13.  Note: each calibration factor (age, geographic, and tobacco) must be calculated independently. |  |  |
| **c** | Tobacco (wellness) factors, projected versus prior:  Compare the 2026 tobacco (wellness) factor and calibration factor to amounts for 2023, 2024 and 2025. |  |  |
| **RISK ADJUSTMENT AND HIGH-COST RISK POOL (HCRP)** | | | | |
| **18** | | **Experience Period Risk Adjustment & HCRP:** |  |  |
|  | **a** | Experience period risk adjustment formula details:  Provide the actual 2024 risk adjustment experience and projections in WA Exhibit 10; see the instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file.  REMINDER: Do **NOT** revise the sign (receivables positive; payables negative) of the actual or projected risk adjustment transfer and HCRP amounts in any exhibit unless specifically instructed to do so. Clearly document the instances when the instructions specify a change in sign. |  |  |
| **b** | Experience period risk adjustment & HCRP by plan:  (URRT Worksheet 2, Section II Experience Period and Current Plan Level Information, Field 2.7)  Using formulae, please address 2024 risk adjustment transfer amounts, HCRP assessments, and HCRP receipts. |  |  |
| **19** | | **Projection Period Risk Adjustment & HCRP:** |  | |
|  | **a** | Projection period incurred risk adjustment & HCRP development:  (URRT Worksheet 2, Section IV Projected Plan Level Information, Fields 4.7 and 4.16)  Provide the projected plan year 2026 risk adjustment information in WA Exhibit 10; see the instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file. |  |  |
| **b** | Projection period risk adjustment & HCRP for URRT Worksheet 2 (on incurred claims basis),  Development and justification:  (URRT Worksheet 2, Section IV Projected Plan Level Information, Fields 4.7 and 4.16)   * Explain in detail in the Part III actuarial memorandum how you estimated the 2026 risk adjustment factors (e.g., PLRS, IDF, GCF, AV, and ARF), including the four membership groupings in (a), as applicable. (See URR Instructions regarding the requirements to provide detailed information and justification for risk adjustment.) * Provide detailed support and rationale for each assumption, including persisting membership, stating the most current data used, its “as of” date, and its source (e.g., internal, CMS, etc.). * Describe how your projections considered the 2026 risk adjustment model changes. * Explain 2026 HCRP estimated assessments and receipts. * We expect the following:   + Since the URRT applies total pool-level projected risk adjustment in Worksheet 1, Section II, the projected risk adjustment loaded into Worksheet 2, Section IV can use total pool-level projections rather than metal or plan projections.   + Applicable risk adjustment transfer amount parameters projected for your own risk pool will be consistent with assumptions in the rate development (e.g., population and other factors in URRT, age and geographic calibration factors, etc.). Please explain any deviations. |  |  |
| **c** | Projection period risk adjustment & HCRP for URRT Worksheet 1 (on allowed claims basis):  (URRT Worksheet 1, Section II Projections)  Provide the calculation of the projected Risk Adjustment Payment/Charge, on an allowed claim dollar basis, as entered in URRT Worksheet 1, Section II. For additional details, see #27 of this checklist. |  |  |
| **d** | Projected 2026 RADV impacts:  Explain in the Part III actuarial memorandum any impacts due to Risk Adjustment Data Validation (RADV) audits. For example, explain any impact to the company or statewide 2026 PLRS projections due to the 2022 RADV audit report. |  |  |
| **e** | HCRP, projected versus prior:  Compare (i) actual HCRP receipts and assessments for 2022, 2023, and 2024 versus (ii) projected HCRP receipts and assessments for 2022, 2023, 2024, 2025, and 2026. Explain differences. |  |  |
| **f** | Projection period risk adjustment transfers & HCRP by plan:  Using formulae, please address 2026 projected risk adjustment transfer amounts, HCRP assessments, and HCRP receipts on an incurred basis. |  |  |
| **RETENTION LOADS**  **URRT WORKSHEET 2, SECTION III PLAN ADJUSTMENT FACTORS, ADMINISTRATIVE COSTS** | | | | |
| **20** | | **Administrative Expense:**  (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.6)  Provide the requested information in WA Exhibit 11; see instructions in the exhibit template.  Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file.  Projection period administrative expense development:   * In the Part III actuarial memorandum and supporting exhibits, justify the 2026 PMPM and/or percent of premium load for each item, and comment why various amounts do or do not vary by plan. * In the Part III actuarial memorandum, justify any item with a $0.00 load. For example, if no offset is projected for investment income, please explain why.   Note: it is insufficient to simply state that an amount is considered immaterial.   * In the Part III actuarial memorandum, describe planned quality improvement initiatives. * At a minimum, include detailed calculations of the following projected amounts: * Quality improvement (QI) expenses * Commissions * Commercial reinsurance premium (if applicable) * Offset for anticipated investment income (if applicable) * General administrative expenses * Note that the commissions load should be consistent with the submitted commission certification (see also #34 of this checklist). The load may include adjustments for bonuses which are not specific to the small group line of business and, therefore, not covered in the certification. Any such bonuses should be explained in the Part III actuarial memorandum and exhibits.   Combine these amounts with actual taxes and fees to reconcile to Expenses shown in the WAC 284-43-6660 summary (see also #21 of this checklist). |  | |
| **21** | | **Taxes and Fees:**  (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.7)  Provide the requested information in WA Exhibit 11; see instructions in the exhibit template.  Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file.  Projection period taxes and fees’ development:   * In the Part III actuarial memorandum and supporting exhibits, justify the 2026 PMPM and/or percent of premium load for each item, and explain why various amounts do or do not vary by plan. * In the Part III actuarial memorandum, justify any item with a $0.00 load.   Note: it is insufficient to simply state that an amount is considered immaterial.   * At a minimum, include detailed calculations of the following projected amounts: * Premium Tax [RCW 48.14.020 or 0201] * Federal Income Tax * Regulatory Surcharge [RCW 48.02.190]   Include a discussion of the current information available at <https://www.insurance.wa.gov/regulatory-surcharge-calculation>.   * Insurance Fraud Surcharge [RCW 48.02.190]   Include a discussion of the current information available at <https://www.insurance.wa.gov/fraud-surcharge-calculation>.   * Risk Adjustment user fee   The 2026 per capita risk adjustment user fee is set at $0.20 PMPM.   * PCORI   Patient-Centered Outcomes Research Institute (PCORI) Fee (Internal Revenue Code sections 4375 and 4376). Include a discussion of the latest information on the IRS website and the National Health Expenditure (NHE) trend projections. Note that the fee changes annually by policy end date. Calculate your fee based on the end date of your policies in the plan year (Q1-3 and Q4 fees); for details, see the IRS Q&A on this topic).   * Mitigating Inequity Fee [WAC 284-43-6590], if applicable (see also #38 of this checklist). * WSHIP assessment [RCW 48.41.090]   Include a discussion of the current and projected assessment information in annual or other reports available at <https://www.wship.org/> as well as the WSHIP information separately sent to you as a member plan. Note: WSHIP = Washington State Health Insurance Pool.   * Washington Partnership Access Line (WAPAL) assessment [WAC 182-110-0500]   Include a discussion of the historical assessments paid and the current information available at <https://wapalfund.org>.   * Combine these amounts with actual administrative expenses to reconcile to Expenses shown in the WAC 284-43-6660 summary. (see also #20 of this checklist) * Some state assessments are charged based on the member’s residence rather than the group’s location. If the carrier chooses to include loads based on the member’s residence:   + Identify each state’s resident-based assessments, including Washington’s. For completeness, include any state with membership but no applicable assessment.   + Show detailed calculations of each amount.   + Compare the current membership distribution by state versus the projected distribution.   Identify the regulatory and/or administrative code authorizing each out-of-state assessment. |  |  |
| **22** | | **Profit & Risk Load:**  (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.8)  Provide the information in WA Exhibit 11; see instructions in the exhibit template.  Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file.   * Profit & Risk load is the portion of the projected earned premium that is not directly associated with claims or expenses. * The amount must be the same across all plans.   Projection period profit & risk load development:  Justify that your Profit & Risk load is reasonable [RCW 48.43.734] in relation to your company’s surplus, capital, and profit levels.   * Discuss in detail how you established your 2026 plan year load. * Clarify whether your experience unpaid claims liability estimate also includes any margin or if the estimate reflects your best estimate. * Explain whether other plan year 2026 rating assumptions include their own margin provisions. |  |  |
| **DOCUMENTATION AND EXHIBITS** | | | | |
| **23** | | **Company Rate Information and Rate Review Detail:**  For the “Company Rate Information” and “View Rate Review Detail” on the Rate/Rule Schedule tab of the SERFF rate filing, provide an exhibit with the following information.   * The information should represent your **initial requested rate change**. * Note: If post submission updates are necessary to correct any information, update the exhibit to indicate what was updated and the reason for the update(s). * Issuers with renewal plans must address the items below. For more information related to “Company Rate Information” and “View Rate Review Detail,” see SERFF and Rate Filing Instructions. |  | |
|  | **a** | SERFF Company Rate Information:  Provide the calculation, explanation, and/or source of the information.  Note the following:   * Number of policy holders affected for this program: The number of subscribers as of March 2025. * Minimum and Maximum % changes: From the initial Uniform Product Modification Justification (UPMJ) Q5 rate changes by plan. * Overall % rate impact: The calculated overall average rate change in UPMJ Q5. * Written Premium for this Program and Written Premium Change for this Program: Annual amounts; see Written Premium in the NAIC glossary. |  |  |
| **b** | SERFF Rate Review Detail (RRD):  Provide the calculation, explanation, and/or source of the information.   * 1. Products, Number of Covered Lives:   The number of covered lives (members) as of March 2025. If applicable, differentiate renewing products which list current lives versus new products which list projected lives (see instructions in the RRD in SERFF).   * 1. Trend Factors:   Annual incurred claims trend factor, including leveraging, which matches the weighted average of the trends by category in the initial 2026 WAC 284-43-6660 summary. (see also #6.b of this checklist)   * 1. Forms:   List all forms for the rate filing in the applicable categories. If a category does not apply to any form in the filing, leave it blank. (see SERFF instructions)  Note: since the ACA requires that all non-grandfathered individual and small group health plans be guaranteed issue, the “Affected Forms for Closed Blocks” in the Forms Section should be left blank.   * 1. Requested Rate Change Information:      + Change period: Annual.      + Member months: Membership for the 2024 experience period.      + Min, Max, and weighted average rate change: Match the initial UPMJ Q5.   2. Prior Rate:      + Total earned premium & total incurred claims: Projected earned premiums and incurred claims, respectively, for 2025.      + Minimum and maximum per member per month (PMPM): Be consistent with the rates in the 2025 final Rate Schedule.      + Weighted average PMPM: Be consistent with the current community rate in the initial WAC 284-43-6660 summary.   3. Requested Rate:      + Projected earned premium & projected incurred claims: For 2026, be consistent with the initial URRT Worksheet 2.      + Minimum and maximum PMPM: From the initial 2026 Rate Schedule.      + Weighted average PMPM: Be consistent with the weighted average PMPM premium rate consistent in the initial URRT Worksheet 2. |  |  |
| **c** | Current enrollment:  Compare current enrollment information across the various rate filing exhibits, including, but not limited to the following:   * RRD Number of Covered Lives. * URRT Worksheet 2, Section II Experience Period and Current Plan Level Information, Field 2.10 Current Enrollment. * UPMJ Q1 Enrollment as of 3/31/2025. * Part III supporting exhibits’ current enrollment.   Explain any inconsistencies. |  |  |
| **d** | Projected enrollment:  Compare projected enrollment information across the various rate filing exhibits, including, but not limited to the following:   * RRD (Projected Earned Premium) / (Requested Rate Weighted Avg. PMPM). * URRT Worksheet 2, Section IV Projected Plan Level Information, Field 4.9 Projected Member Months. * Part II written explanation projected enrollment. * Part III supporting exhibits’ projected enrollment.   Explain any inconsistencies. |  |  |
| **24** | | **Impacts of Changes 45 CFR §154.301(a)(4):**   * Document the methodology, justification, and calculations used to determine the impacts of the changes outlined in the Effective Rate Review Program under 45 CFR §154.301(a)(4) (i) through (xv). * Note that if you change the contribution to surplus from the prior submission, you must provide additional support for why the change is warranted. * *To add context to the factors listed below, please also summarize in the Part III actuarial memorandum the approximate percent impact of the most significant contributors* ***to the proposed aggregate rate change*** *(see URR Instructions section 4.3, for example)*. |  | |
| (i) The impact of medical cost trend ***changes by major service category***. Include a discussion of the cost trend change for each specific benefit category listed in URRT Worksheet 1, Section II. |  |  |
| (ii) The impact of utilization ***changes by major service category***. Include a discussion of the utilization trend change for each specific benefit category listed in URRT Worksheet 1, Section II. |  |  |
| (iii) The impact of cost-sharing ***changes by major service category***, including actuarial values. Include a discussion of the cost-share changes for each specific benefit category listed in URRT Worksheet 1, Section II. |  |  |
| (iv) The impact of benefit *changes*, including essential health benefits (EHBs) and non-essential health benefits (non-EHBs).  Address the new essential health benefits for non-grandfathered individual and small group health insurance coverage in the State of Washington for plan years beginning on or after January 1, 2026. For each new EHB, describe whether your plan designs already covered the benefit or describe what plan design changes were required. Clearly demonstrate and justify any rate changes due to these new EHBs. |  |  |
| (v) The impact of *changes in* enrollee risk profile and pricing, including rating limitations for age and tobacco use under section 2701 of the Public Health Service Act. |  |  |
| (vi) The impact of any *overestimate or underestimate* of medical trend for prior year periods related to the rate increase. Include a discussion and analysis of actual to expected medical trends. |  |  |
| (vii) The impact of *changes in* reserve needs. Include a discussion of any change in reserve needs. |  |  |
| (viii) The impact of *changes in* administrative costs related to programs that improve health care quality. Include a discussion of any such changes. |  |  |
| (ix) The impact of *changes in* other administrative costs. Include a discussion of any such changes. |  |  |
| (x) The impact of *changes in* applicable taxes, licensing, or regulatory fees. Include a discussion of any such changes. |  |  |
| (xi) Medical loss ratio (MLR). Include a projected federal MLR calculation [45 CFR §158.221; see also CMS MLR Filing Instructions].  Note: This is one of only two 45 CFR §154.301(a)(4) items not written in terms of the impact of changes; the other is (xii) for the issuer's capital and surplus.  Note: As stated in the Final 2026 NBPP, determination of a “qualifying issuer” is “based on an issuer’s 3-year aggregate ratio of net payments related to the risk adjustment program…to earned premiums.” See 45 CFR §158.103 for full definition details.   * *Issuers who (a)* ***are NOT******projected******to be qualifying issuers*** *or (b)* ***are projected to be qualifying issuers but opt to follow the unadjusted MLR formula****, as defined in the Final 2026 Notice of Benefit and Payment Parameters (NBPP)*:   + Numerator:   Incurred claims [45 CFR §158.140(a)]  – Net Risk Adjustment, including HCRP amounts (receivables positive; payables negative, which means that payables subtract negative amounts)  + Quality Improvement Expenses [45 CFR §158.150(a)]   * + Denominator:   Earned Premiums [45 CFR §158.130]  – Taxes & Fees [45 CFR §§ 158.161(a) and 158.162(a)(1) and (b)(1)]  – Community Benefit Expenditures (CBE) [45 CFR §158.162(c) and 2023 MLR Filing Instructions]   * *Issuers who* ***are projected to be qualifying issuers and opt to follow the adjusted MLR formula****, as defined in the Final 2026 Notice of Benefit and Payment Parameters (NBPP)*:   (See also the formula below written with variables, copied from the Final 2026 NBPP.)   * + Numerator:   Incurred claims [45 CFR §158.140(a)]  + Quality Improvement Expenses [45 CFR §158.150(a)]   * + Denominator:   Earned Premiums [45 CFR §158.130]  – Taxes & Fees [45 CFR §§ 158.161(a) and 158.162(a)(1) and (b)(1)]  + Net Risk Adjustment, including HCRP amounts (receivables positive; payables negative, which means that payables add negative amounts)  – Community Benefit Expenditures (CBE) [45 CFR §158.162(c) and 2023 MLR filing instructions]   * If CBE are included, provide justification that includes the following details:   + How total CBE are allocated to lines of business (e.g., individual, small group, and large group)   + For federal tax-exempt issuers:     - CBE are limited to the highest of either:     - Three percent of earned premium; or     - The highest health insurance coverage premium tax rate in the State for which the report is being submitted, multiplied by the issuer's earned premium in the applicable State market.     - Please address the impact, if any, of capping CBE for MLR purposes.     - MLR reporting instructions say federal tax-exempt issuers may report a value for both state premium taxes and CBE if reported CBE do not exceed the allowable capped amount (as outlined above). If you are a federal tax-exempt issuer, please confirm this requirement has been met.   + For non-federal tax-exempt issuers:     - CBE are limited to:   The highest health insurance coverage premium tax rate in the State for which the report is being submitted, multiplied by the issuer’s earned premium in the applicable State market.   * + - Please address the impact, if any, of capping CBE for MLR purposes.     - MLR reporting instructions say non-federal tax-exempt issuers may report a value for state premium taxes or CBE but not both. Issuers may not report zero ($0) CBE in lieu of negative State premium taxes and may not enter CBE more than the allowable capped amount. If you are a non-federal tax-exempt issuer, please confirm this requirement has been met. * Credibility adjustment, if any [45 CFR §158.232] * Comment about how the following recent MLR reporting regulation changes were considered: [See, for example: 45 CFR §158 and related sections as well as various Final plan year NBPPs]   + Adjustments to the numerator:     - Deduct from incurred claims not only prescription drug rebates received by the issuer, but also any price concessions received and retained by the issuer, and any prescription drug rebates, and other price concessions received and retained by an entity providing pharmacy benefit management services to the issuer. [45 CFR 158.140(b) and 2022 NBPP]     - Beginning with the 2020 MLR reporting year, an issuer may include in the numerator of the MLR any shared savings payments the issuer has made to an enrollee as a result of the enrollee choosing to obtain health care from a lower-cost, higher-value provider. [45 CFR §158.221(b)(8)]   + Report expenses for services outsourced to or provided by other entities in the same manner as expenses for non-outsourced (i.e., incurred directly by the issuer) services. [45 CFR §158.110(a) and 2021 NBPP]   + Quality Improvement Activity (QIA) expenses:     - Only those provider incentives and bonuses that are tied to clearly defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers may be included in incurred claims for MLR reporting and rebate calculation purposes. (e.g., see 2023 NBPP)     - Only expenditures directly related to activities that improve health care quality may be included in QIA (Quality Improvement Activity) expenses for MLR reporting and rebate calculation purposes. [45 CFR §158.150(a) and 2023 NBPP]     - *Removing* the option for issuers to report an amount equal to 0.8 percent of earned premium in the relevant State and market in lieu of reporting the issuer’s actual expenditures for activities that improve health care quality (e.g., see 2022 NBPP).   + MLR rebate prepayment and safe harbor [45 CFR §158.240(g)]:   Allowance to prepay a portion or 100% of an estimated MLR rebate for a given MLR reporting year, and establishing a safe harbor allowing such issuers, under certain conditions, to defer the payment of rebates remaining after prepayment until the following MLR reporting year (e.g., see 2022 NBPP).   * Replacement formula for qualifying issuers (e.g., see 45 CFR §158.103 for definition of qualifying issuer), written with variables:   If (ra / p) > or = 50%, then:  Adjusted MLR = [(i + q – s + nc – rc) / {(p + s – nc + rc) – t – f – (s – nc + rc) – na + ra}] + c  where  i = incurred claims  q = expenditures on quality improving activities  p = earned premiums  t = Federal and State taxes  f = licensing and regulatory fees including $0 for transitional reinsurance contributions  s = issuer’s transitional reinsurance receipts (=$0)  na = issuer’s risk adjustment related payments  nc = issuer’s risk corridors related payments (=$0)  ra = issuer’s risk adjustment related receipts  rc = issuer’s risk corridors related receipts (= $0)  c = credibility adjustment, if any |  |  |
| (xii) The health insurance issuer's capital and surplus (i.e., if and how rate development considered your issuer’s current capital and surplus levels). For example, are changes required to your issuer’s premium to surplus ratio? Include a discussion in the Part III actuarial memorandum.  Note: This is one of only two 45 CFR §154.301(a)(4) items not written in terms of the impact of changes; the other is (xi) for MLR. |  |  |
| (xiii) The impacts of geographic factors and variations. |  |  |
| (xiv) The impact of *changes within* a single risk pool to all products or plans within the risk pool. |  |  |
| (xv) The impact of reinsurance (which is N/A for Washington) and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act. |  |  |
| **25** | | **Drug Manufacturer Support of Member Out-of-Pocket Costs:**  Per revised 45 CFR §156.130(h), for plan years beginning on or after January 1, 2020, amounts paid toward cost sharing using any form of direct support offered by drug manufacturers to insured patients to reduce or eliminate immediate out-of-pocket costs for specific prescription brand drugs are permitted, but not required, to be counted toward the annual limitation on cost sharing. RCW 48.43.435 further outlines requirements for plans issued or renewed on or after January 1, 2024.  Indicate what you implemented related to these requirements and justify any impact to your rate development. |  |  |
| **26** | | **Financial Statement Analysis:** |  | |
|  | **a** | Reconcile to Additional Data Statement (ADS) for the year ending December 31, 2024:   * For carriers not required to file an ADS, please respond “N/A.” For ease of review for carriers who file an ADS, please include with the rate filing a copy of the ADS pages. * For HMOs and HCSCs, show ADS amounts total revenues (line 7), total hospital and medical claims (line 17), and administrative expenses (line 19 + line 20). * Please include a detailed list of adjustments required to reconcile between ADS amounts and amounts in the Summary of Pooled Experience in the WAC 284-43-6660 summary and in URRT Worksheet 1, Section I. Calculate the amount and percentage unreconciled and explain any significant unreconciled amounts. * Explain any difference in the projected risk adjustment amount included in the ADS premium amount versus the experience period risk adjustment amount entered in URRT Worksheet 1, Section I. * Also, compare the average monthly membership from the WAC 284-43-6660 summary’s 2024 experience period with the average monthly membership calculated from the quarter ending enrollment listed in the ADS. Explain any significant differences. |  |  |
|  | **b** | Months of surplus:  For all issuers, please provide a calculation of your company’s Months of Surplus using information in the 2024 annual statement and one of the following formulas, with one decimal place of accuracy.  Health Statement: Months of Surplus = [(Annual Statement Page 3, Line 33: Total capital and surplus) / (Page 4, Line 18: Total hospital and medical (Lines 16 minus 17))] \* 12.  Life Statement: Months of Surplus = [(Annual Statement Page 3, Line 38: Total (Lines 29, 30, & 37)) / (Page 4, Line 20: Total (Lines 10 to 19))] \* 12. |  |  |
| **SEPARATE DOCUMENTS**  Address the following items together with other relevant items covered elsewhere in this checklist. | | | | |
| **27** | | **Part I Unified Rate Review Template (URRT):**  Note: The various index rates (Index Rate, MAIR, etc.) in the URRT are the official amounts. For calculations in your supporting exhibits requiring one of these amounts, such as the Exchange User Fee input for URRT Worksheet 1 Section II, please use and reference the applicable amount(s) calculated in the URRT.  Please do not disable the macros in the Excel version of the URRT; please submit a macro-enabled URRT workbook.  The URRT worksheets allow up to 16 characters including decimal places. Only apply rounding to amounts directly loaded into the URRT and only to the extent necessary to meet the 16-character limitation. Do not round any intermediate amounts. |  | |
|  | **a** | URRT Exchange User Fees:  (URRT Worksheet 1, Section II Projections)  If the issuer is only outside the exchange, please respond “N/A.”  The Exchange user fee for 2026 is $5.11 PMPM.   * For issuers marketing both inside and outside the Exchange, confirm that the Exchange user fees, or Exchange assessment fees, are spread across the entire pool. * For issuers only marketing inside the Exchange: The default expectation is that 100% of membership will be on the Exchange. If your project less than 100% Exchange membership, include an explanation in the Part III actuarial memorandum. * Justify the Exchange User Fees’ percentage load entered in URRT Worksheet 1, Section II. Compare the result against the required amount per member per month (PMPM). There should be a reasonable assumption for the distribution of enrollees inside and outside the Exchange. * If any Exchange membership is projected for plan year 2026, please check that a nonzero dollar amount flows through to URRT Worksheet 1, Section II Exchange User Fees. * Ensure the amount is adjusted to reflect an allowed dollar basis as discussed in #27.b of this checklist. | **N/A** | **Note: Per Washington Health Benefit Exchange (WAHBE), there will be no Exchange SHOP plans for small groups for plan year 2026, so the amount should be $0 and 0%.** |
| **b** | URRT factor to toggle between worksheet 1 and worksheet 2 amounts  for risk adjustment transfers and Exchange user fees:  Justify the factor used to develop Risk Adjustment Payment/Charge and Exchange User Fees for URRT Worksheet 1, Section II. The adjustment should be the aggregate impact of the four plan factors from URRT Worksheet 2, Section III Plan Adjustment Factors (i.e., Fields 3.3, 3.4, 3.5, and 3.9). Later URRT steps apply the plan factors through multiplication; to neutralize the overall impact, URRT Worksheet 1 needs to divide by their aggregate impact. |  |  |
| **c** | URRT Worksheet 1, Section II, 2026 versus 2025:  Compare the projections in URRT Worksheet 1, Section II in this year’s filing for 2026 versus those in last year’s filing for 2025. |  |  |
| **d** | URRT Worksheet 2 terminated plan mapping:  Document and justify URRT Worksheet 2 product and plan mapping for terminated plans, in accordance with the following:   * For the inside Exchange plans and plans that are both inside and outside Exchange, follow the mapping information you (the issuer) provided to WAHBE and as required by 45 CFR §155.335(j). * For the outside Exchange plans, follow your procedure as indicated in the letter(s) provided to the policyholder(s) and consistent with Uniform Product Modification Justification (UPMJ).   Note: each 2025 plan should map all members in the plan to the same 2026 plan.  Respond “N/A” if no 2025 plans are terminating. |  |  |
| **e** | URRT Worksheet 2, Section I, general product and plan information,  Cumulative rate change % for composite plans:  For any plan in URRT Worksheet 2 which is the composite of more than one plan in UPMJ Q5, include an exhibit detailing the calculation of the Cumulative Rate Change % (over 12 mos. prior) based on the overall average rate change by plan in UPMJ Q5.  If there are no composite plan rate changes, respond as “N/A.” |  |  |
| **f** | URRT Worksheet 2, Section IV Projected Plan Level Information  Projected allowed claims, incurred claims & premiums:   * Include an exhibit that calculates the projected dollar amounts by plan for URRT Worksheet 2, Section IV Projected Plan Level Information. * For clarity, please also show calculations of the plan-specific and aggregate projected PMPM amounts for Fields 4.11 through 4.17. * Aggregate amounts should reconcile as demonstrated in WA Exhibit 12; see instructions in the exhibit template. Provide supporting technical details, as needed, in issuer-created actuarial exhibits submitted separately from the exhibit template file.   Note that although reconciliation is expected in aggregate, differences may be reasonable for specific plans.   * Note that the following results are expected: * The Total Allowed Claims PMPM in Field 4.11 should be consistent with the [Projected Index Rate] + [average PMPM of the CSR load (on an allowed basis)] + [average PMPM for non-EHB, excluding abortion services reported as non-EHB (on an allowed basis)]. * The Allowed Claims PMPM by plan in Field 4.11 should only differ from the Total Allowed Claims PMPM due to URRT Worksheet 2, Section III Plan Adjustment Factors, Fields 3.3 AV and Cost Sharing Design of Plan (a.k.a. Pricing AV), 3.4 Provider Network Adjustment, 3.5 Benefits in Addition to EHB, and 3.9 Catastrophic Adjustment. |  |  |
| **g** | URRT projected members by plan:  Please document the following in the Part III actuarial memorandum:   * Explain how member months were projected by plan. * Explain how URRT membership projections align with 2026 company expectations for the product line. * Justify any new or renewing plans with zero projected enrollment. * If the opining actuary relied on membership projections from another area of your company, please indicate as such in the reliance section of the actuarial certification. |  |  |
| **h** | URRT projected PAIR versus premium PMPM:  Compare the weighted-average Plan Adjusted Index Rate (PAIR; URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.10) to the aggregate premium PMPM projected in Field 4.17. Weight the PAIR amounts by projected member months. Explain any differences. |  |  |
| **i** | URRT controlled group renewal clarification:  Based on input from CMS/CCIIO, if you are an issuer renewing only one 2025 plan that will be offered by a health insurance issuer within your controlled group, please include the following (see also #29.b and #30.c of this checklist).  If not applicable, indicate “N/A.”  In URRT Worksheet 2, Section I General Product and Plan Information and Section II Experience Period and Current Plan Level Information, for the current and new issuers:   * The Plan Name (Field 1.3) and Plan ID (Field 1.4) will be unique to each issuer. * Indicate the plan as a renewing plan (Field 1.7). * Include the current rate from the current issuer (Field 2.11) in the new issuer’s URRT. * Use the current rate in the calculation of the rate increase (Field 1.11) in the new issuer’s URRT. * For consistency across the worksheets, only include experience in the current issuer’s URRT Worksheets 1 and 2. |  |  |
| **28** | | **Part II Written Description Justifying the Rate Increase:**   1. Follow content guidance outlined in URR Instructions. 2. Include key drivers of the risk pool’s rate increase as well as relevant plan details such as those described below.  * Changes in Benefits:   Consumers tend to view cost-share changes as “benefit changes,” so a summary of the cost-share changes should be included in this section, along with other significant benefit changes. Note: the cost-share changes in this document should just be an overview of major changes, such as general discussion of the range of deductibles or changes in copays, rather than a repeat of the detailed list in UPMJ Q4a & 4b.   * Administrative Costs and Anticipated Margins:   Consumers tend to view all retention loads, other than profit, as “administrative costs,” so taxes and fees should be included in this section along with other administrative expenses.   * Please also note the pool’s projected profit & risk load. |  |  |
| **29** | | **Part III Actuarial Memorandum and Certification:**   * Submit the actuarial memorandum exhibits in a separate Excel spreadsheet and corresponding PDF. Note: the PDF version of the actuarial memorandum exhibits can be submitted on the URRT tab rather than the Supporting Documentation tab in SERFF so that it will be uploaded to CMS. The Excel spreadsheet, however, must be submitted on the Supporting Documentation tab. * Note: to reduce the review time required to sift through duplicate file versions, please do NOT submit additional complete copies of the URRT worksheets, the WAC 284-43-6660 summary, or the Rate Schedules with the actuarial memorandum exhibits. * Note: The State of Washington requires that the redacted actuarial memorandum must match the unredacted actuarial memorandum. |  | |
|  | **a** | Actuarial certification:  Include an actuarial certification as prescribed in the Part III Actuarial Memorandum and Certification Instructions found in the URR Instructions. Include the signature date in the signatory block of the certification and update the date throughout the filing review season, as needed, if assumptions or rates change. |  |  |
| **b** | Controlled group renewal clarification for Part III:  Based on input from CMS/CCIIO, if you are an issuer renewing only one 2025 plan that will be offered by a health insurance issuer within your controlled group, please include the following (see also #27.i and #30.c of this checklist).  If not applicable, indicate “N/A.”  In both the current and new issuers’ Part III actuarial memorandums, add a crosswalk detailing the current and renewing plan information. Include:   * The name of the current and new issuers offering the plan. * A comparison of the 2025 and 2026 HIOS Plan IDs and plan names. * A comparison of the 2025 counties in the service area for the renewing plan and the 2026 counties offered by the new issuer to demonstrate meeting the requirement to cover a majority of the same service area. * Discuss the cost-share changes to the plan and confirm that the product network type and covered benefits remain the same. |  |  |
| **c** | UPMJ versus URRT rate changes:  Rate changes by plan in URRT Worksheet 2, Section I General Product and Plan Information, Field 1.11 should match rate changes by plan in UPMJ Q5. For clarity, discuss in the Part III actuarial memorandum the differences in the calculation of the official aggregate rate change in UPMJ Q5 and the rate change amounts in URRT Worksheet 2, Section I General Product and Plan Information, Fields 1.12 and 1.13. |  |  |
| **30** | | **Uniform Product Modification Justification (UPMJ):**  Review and follow the general instructions as well as the UPMJ instructions for each question.  The UPMJ template can be found on the [Washington State OIC website](https://www.insurance.wa.gov/speed-market-tools-health-coverage-analysts). |  | |
|  | **a** | UPMJ Q4a & 4b:   * For UPMJ Q4a, keep in mind that the content will ultimately be included in our decision memorandum that is posted for public consumption, so explain the cost-share changes as you would to an existing or prospective member. * For each cost-share amount listed in UPMJ Q4a, include dollar, comma, and percent symbols as well as numeric amounts. * Spell out the first occurrence of each acronym in Q4a and Q4b. For example, “Maximum Out-of-Pocket (MOOP).” * Note: For plans that add or remove out-of-network (OON) coverage, the change should be listed as a member cost-share change rather than a benefit change. |  |  |
| **b** | UPMJ Q5:   1. Column 5(d):    * + - Only include enrollment from renewing counties.        - If you are exiting any counties, please address the following:   Since you are exiting counties, total enrollment in Q5 may not match the UPMJ Q1 total, so include an exhibit in the filing with current enrollment by plan split between renewing and terminating counties. Note that UPMJ Q1 should include all enrollment before reductions for terminating counties.   1. Display rate changes for every renewing and terminated plan, even if the 03/31/2025 enrollment is 0. A plan should only reflect 0.00% across columns 5(g), 5(h), 5(i), and 5(j) if there are no experience, benefit, and cost-share rate changes for the plan. 2. Submit an exhibit supporting rate changes for each UPMJ Q5 column.    * Ensure UPMJ Q5 rate changes are consistent with the benefit and cost-share changes in UPMJ Q4a and Q4b.    * Justify each rate change by showing the calculation or explaining how the percentages were determined and ensure rate filing documents consistently support the rate changes.    * Explain how plan-specific rate changes disregard the morbidity of the population expected to enroll in each plan.    * Note that it is acceptable to back into column 5(g), Experience Rate Change for Plan, using justified amounts for 5(j), Overall Average Rate Change for Plan; 5(i), Cost-Share Rate Change for Plan; and 5(h), Benefit Rate Change for Plan.    * Explain any large plan variations in 5(g), Experience Rate Change for Plan. We expect that there should be little variability due to the single risk pool requirement.    * Specify the source of the 2025 and 2026 rates used to calculate the overall increase for each plan. The changes should be consistent with the changes to the Rate Schedule. They should be weighted by the plan’s current enrollment distribution for age, geographic area, and wellness program participation status (see URR Instructions 2.2.1 and 4.3). |  |  |
| **c** | Controlled group renewal clarification for UPMJ:  Based on input from CMS/CCIIO, if you are an issuer renewing only one 2025 plan that will be offered by a health insurance issuer within your controlled group, please include the following (see also #27.i and #29.b of this checklist).  If not applicable, indicate “N/A.”   * *Current issuer*: UPMJ Q4a and Q5b will be blank. * *New issuer*: UPMJ Q4a must include the benefit changes from the current issuer’s plan to the new issuer’s plan. Q5b should include a line with the new plan’s rate change percentage with zero members. |  |  |
| **d** | Quarterly trend factors:   * Document and justify the quarterly premium trend factors. * Compare the 2026 quarterly premium trend factors with those used in 2023, 2024, and 2025. |  |  |
| **31** | | **WAC 284-43-6660 summary:**  Complete and submit the template “Format – Rates – WAC 284-43-6660 Summary Duplicate” provided on the [Washington State OIC website](https://www.insurance.wa.gov/speed-market-tools-health-coverage-analysts). See below for additional information. |  | |
|  | **a** | Proposed rate summary:   * Proposed Community Rate must be consistent with the aggregate projected premium PMPM in URRT Worksheet 2, Section IV Projected Plan Level Information, Field 4.17. * Percentage Change must be consistent with the overall average rate change in UPMJ Q5b. * Current Community Rate = (Proposed Community Rate) / (1 + Percentage Change). |  |  |
| **b** | Components of proposed community rate:   * Component (a) Claims should match (URRT Worksheet 2, Section IV Projected Plan Level Information, Field 4.15 Incurred Claims PMPM) minus (URRT Worksheet 2, Section IV Projected Plan Level Information, Field 4.16 Risk Adjustment Transfer Amount PMPM). * Component (b) Expenses combined with component (d) Investment Earnings must be consistent with the combined values of (Exchange User Fees in URRT Worksheet 1, Section II) + (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.6 Administrative Expense) + (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.7 Taxes and Fees). * Component (c) Contribution to Surplus Contingency Charges, or Risk Charges must be consistent with (URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.8 Profit & Risk Load). * Total row (e) must match the Proposed Community Rate from #31.a above (i.e., Proposed rate summary) in the WAC 284-43-6660 summary. |  |  |
| **c** | Trend factor summary:  (see also #6.b of this checklist)   * If the WAC 284-43-6660 summary shows the same trend for each type of service, please explain whether you expect any variation by type of service. If variation is expected, please explain the choice of a single trend factor for this summary. * For plans with embedded dental (pediatric or adult), ensure the embedded dental trend is included in the Other trend category, and then add a note to the General Information section #5 that the embedded dental trend is included in the Other trend category. This is to be consistent with the URR Instructions, section 2.1.3.1. |  |  |
| **d** | General Information section #4:  Respond with “See Rate Schedule.” |  |  |
| **32** | | **Benefit Components:**  Provide a completed Benefit Components Speed-to-Market Tool.   * The file “Format - Rates - 2026 Med Benefit Components” is provided on the [Washington State OIC website](https://www.insurance.wa.gov/speed-market-tools-health-coverage-analysts). * The cost-shares for all embedded benefits, including pediatric dental, must have every different cost-share visible such as for different kinds of pediatric dental care (e.g., cleaning versus extensive surgeries, or as preventive, basic, major services), if applicable. * Note, the information you provide in this file should be consistent with the other documents in your binder, rate, and form filings (e.g., PBT, AVC Screenshots, MH/SUD Certification). * The plans should indicate integrated or separate medical and drug deductibles consistent with the AVC screenshots (see also #9 of this checklist). |  |  |
| **33** | | **Mental Health and Substance Use Disorder (MH/SUD) Financial Requirement Parity:** |  | |
|  | **a** | MH/SUD financial requirement parity certification:  Complete the “Mental Health and Substance Use Disorder Financial Requirement Parity Certification” Speed-to-Market Tool.  See file “Certification – Rates – 2026 Mental Health and Substance Use Disorder Financial Req Parity” on the [Washington State OIC website](https://www.insurance.wa.gov/speed-market-tools-health-coverage-analysts). |  |  |
| **b** | MH/SUD parity calculations:  Complete an MH/SUD Parity Speed-to-Market Tool that documents MHSUD financial requirement parity testing calculations.  See file template “Certification - Rates - 2026 Mental Health and Substance Use Disorder Financial Req Parity Calculations” on the [Washington State OIC website](https://www.insurance.wa.gov/speed-market-tools-health-coverage-analysts).   * In the Mapping Information and each MHSUD Parity Testing Worksheet, please use the same benefit descriptions listed (both EHB and non-EHB) in the Benefit Components. The list should include all benefits, including inpatient, emergency care and prescription drugs. * Carriers must either test all outpatient services in one category or test both outpatient office visits and all other outpatient services separately. * Categories can be split in some cases if, for example, you want to split services between office visits and all other outpatient services. If you combine categories, indicate in the notes which categories are included. For example, a therapies category in the testing can combine rehabilitative speech therapy and rehabilitative occupational and physical therapies from the Benefit Components. * For easy comparison, enter the plans in the same order and use the same tab names in the MHSUD Parity and Benefit Components workbooks. It would also be helpful if the Service Descriptions in the worksheets are in the same order as the Benefit Components. * Plan projected allowed amounts should be annual dollar amounts which reflect a reasonable projected dollar amount [WAC 284-43-7040(1)(c)(ii)] as attested to in the MH/SUD Financial Requirement Parity Certification (section II.B.2). The amounts should be consistent with the allowed claims projected in URRT Worksheet 2, Section IV Projected Plan Level Information. * The cost-shares for all embedded benefits, including dental and vision, must have every different cost-share visible, such as for different kinds of pediatric dental care, in the list of medical/surgical benefits. * As noted in WAC 284-43-7020(5)(a), a plan or issuer must treat the least restrictive level of the financial requirement limitation that applies to at least two-thirds of medical/surgical benefits across all provider tiers in a classification as the predominant level that it may apply to mental health or substance use disorder benefits in the same classification.   In the case of multiple cost shares across provider tiers, we recommend demonstrating parity by comparing each tier’s MH/SUD cost shares versus the least restrictive level of medical/surgical benefit cost shares across all provider tiers in the classification. |  |  |
| **34** | | **Commission Certification:**  (see also #20.a of this checklist)  Provide detailed proposed commission schedules, even if no commissions are expected to be paid for this block of business for plan year 2026. They should be signed and dated by an officer or a senior manager of your company who oversees commission schedule implementation. The officer or senior manager should certify that the information is accurate to the best of their knowledge at the time of the rate submission. The commission schedule must comply with CMS guidance below and 45 CFR §147.104(e) and §156.225(b).  <https://www.cms.gov/files/document/agent-broker-compensation-and-guaranteed-availability-coverage.pdf?utm_content=&utm_medium=email&utm_name=&utm_source=govdelivery&utm_term=>  Commission schedules should not differ for special enrollment periods.  Broker bonus programs determined across multiple lines of business are not part of this certification, but they should be noted and accounted for in the rate development.  Note: Commission schedules filed in individual and small group rate filings must be finalized prior to the final disposition. The commission schedule will not be allowed to change after the rate filing is approved. |  |  |
| **35** | | **Rate Schedule:**  Provide a complete rate schedule using the “[Format - Rates - 2026 Individual Non-grandfathered Health Plan Rate Schedule template](https://www.insurance.wa.gov/speed-market-tools-health-coverage-analysts).” Be mindful of the following:   * Use the most current version of the template. * The 1.0000 premium rates (age factor 1.0000 such as for age 21; wellness discount 1.0000; area factor 1.0000) should be consistent with the Calibrated Plan Adjusted Index Rate (CPAIR) amounts in URRT Worksheet 2, Section III Plan Adjustment Factors, Field 3.14. (see also #11.e of this checklist) * Submit on the Rate/Rule Schedule tab in SERFF. |  |  |
| **36** | | **Rate Example (other than for composite rating):**  (See #37 below for composite rating.)  Submit a rate calculation example on the Rate/Rule Schedule tab in SERFF. Address the following:   * Use the rates in the Rate Schedule. * Include a statement that rates are charged to no more than the three **oldest** covered children under 21 for family coverage [45 CFR §147.102(c)(1)]. * If your premium rates adjust for tobacco/wellness, please include in the example at least one family member whose rates would be impacted. |  |  |
| **37** | | **Composite Rate Example:**  (See #36 above for a rate example not impacted by composite rating.)  Is composite rating allowed for any of your small group plans in this filing? If yes, address items (a) and (b) below.  If no, please respond “N/A.”   * For each plan, explain in detail whether composite premium setting under 45 CFR §147.102(c)(3) is an available choice for small employers. * Submit all composite examples in a single document on the Rate/Rule Schedule tab in SERFF. |  | |
|  | **a** | Illustrative example for composite rating:   * Include an illustrative example as a separate document in the Rate/Rule Schedule tab and name the file “Illustrative Example for Composite Rating.” * Use the rates in the Rate Schedule. * Show how to calculate a two-tiered-only composite premium structure for a small employer that satisfies the following requirements: * The composite premium for covered adults ages 21 and older is the average enrollee premium amount calculated at the beginning of the plan year for covered adults ages 21 and older, regardless of whether they are an employee or adult dependent. * The composite premium for covered individuals under age 21 is simply the average enrollee premium amount for covered individuals under age 21. * Explain how you handle the possibility of a small group which does not start with covered individuals under age 21. Would you allow composite rating in these cases? If yes, would you use a default age distribution to set up the group or wait to set an under-21 rate until an under-21 enrollee is ready to join the group? * The premium for a given family composition is determined by summing the average enrollee premium amount applicable to each family member covered under the plan, considering no more than three covered children under age 21. * The average enrollee premium amount calculated for any individual covered under the plan does not include any rating variation for tobacco use (Under Federal rule, for small group plans, tobacco use factor must be tied to wellness activities defined in Federal rule). The rating variation for tobacco use is determined based on the premium rate that would be applied on a per-member basis with respect to an individual who uses tobacco and then included in the premium charged for that individual. * If a composite premium is chosen by a small employer, an average enrollee premium amount calculated based on applicable enrollment of participants and beneficiaries at the beginning of the plan year does not vary during the plan year with respect to a particular plan, even if the composition of the group changes. The issuer would recalculate the average enrollee premium amount for the group only upon renewal. |  |  |
| **b** | Form filing that addresses composite rating:  Provide the form filing tracking number, document name(s), and language that meet the requirements stated above. |  |  |
| **38** | | **Requirements for Mitigating Inequity in the Health Insurance Market [WAC 284-43-6590]:**  If applicable, submit a separate certification detailing the calculation of a fee for excluding any benefit mandated or required by Title 48 RCW or rules adopted by the commissioner. A member of the American Academy of Actuaries (MAAA) must sign the certification. (see also #21.a of this checklist) |  |  |
| **39** | | **Use of Artificial Intelligence, Machine Learning, and/or Predictive Modeling:**  In preparing assumptions and premium rates for this rate filing, did your company rely on artificial intelligence techniques, machine learning techniques, and/or other predictive modeling methods? Please explain any such reliance including the models and where the results applied to the rate filing. Please explain how your actuary fulfilled professionalism requirements including those in the Code of Professional Conduct and Actuarial Standards of Practice (ASOPs), such as ASOP No. 56, *Modeling*. Include comments about how you evaluated results for reasonableness.  Consider, for example, the September 2024 professionalism discussion paper, “Actuarial Professionalism Considerations for Generative AI,” published by the American Academy of Actuaries. |  |  |